Pure Resolutions LLC

An Independent Review Organization

Phone Number: **(817) 779-3288**

990 Hwy. 287 N. Suite 106 PMB 133
Mansfield, TX 76063
Email:pureresolutions@irosolutions.com

Fax Number: **(817) 385-9613**

Notice of Independent Review Decision

Case Number:

Date of Notice: 01/20/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

3D cervical CT w/o contrast

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

The patient is a male who sustained an injury on xx/xx/xx while carrying a large heavy bag. The patient is noted to have had prior lumbar fusion procedures completed in December of 2013 as well as a remote anterior cervical discectomy and fusion at C5-6 completed 12 years prior. The patient was seen on 11/07/14 with complaints of pain in the cervical region radiating to the left shoulder and left hand with associated numbness and tingling. The patient had been treated with steroids and physical therapy was ordered. The physical examination noted limited range of motion in the cervical spine with 2+ and symmetric reflexes in the upper extremities. There was diminished sensation in the left hand and left thumb.
Spurling's maneuver was noted to be positive to the left. MRI studies of the cervical spine were ordered and completed on 11/07/14. The study noted a disc osteophyte complex at C3-4 slightly flattening the cervical spinal cord with the canal measuring 11mm. No cord edema was present. There was severe bilateral foraminal stenosis at C3-4. Some mild left foraminal stenosis due to facet osteoarthritis was noted at C4-5. Postoperative changes at C5-6 were noted. At C6-7 there was a disc osteophyte complex without contact of the spinal cord with severe left foraminal stenosis present due to unconvertible osteophyte formation. The patient was seen on 11/18/14 with continuing complaints of pain in the neck radiating to the left upper extremity. Medications at this visit included Lyrica, Tramadol, and Naprosyn as well as Methadone. The patient's physical examination noted intact strength in the upper extremities. No gait imbalance was present. reviewed the MRI studies of the cervical spine. did have concerns of pseudoarthrosis at C5-6 and CT studies were recommended to assess for cervical nonunion. No plain film radiographs were evident.

The submitted request for CT scans of the cervical spine with 3D reconstruction were denied by utilization review on 12/12/14 and then again on 12/22/14 as prior films did rule out cervical nonunion and there were no pertinent neurological findings to support the need for CT studies.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The patient has presented with persistent complaints of neck pain radiating to the left upper extremity that have not improved with conservative efforts to date. MRI studies of the cervical spine did note a prior cervical fusion at C5-6 without any concerning findings for stenosis. There was severe left foraminal narrowing noted to the left at C6-7. The patient's objective findings did note sensory loss in the left hand involving the thumb and index finger and positive Spurling's signs were evident. There were no plain film radiographs of the cervical spine completed to date that were either positive or equivocal for evidence of pseudoarthrosis at C5-6. In this reviewer's opinion, the patient's presentation is more consistent with disc pathology at C6-7 which has already been described on MRI studies. At this point in time without plain film radiographs, it is unclear what additional evidence CT studies of the cervical spine would provide to help delineate treatment options for the patient. Therefore, it is this reviewer's opinion that medical necessity is not established at this time and the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)